STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING 00		COMPLETED	
						05/29/	2013
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					96TH ST		
RITTENH	IOUSE SENIOR LIV	VING OF INDIANAPOLIS		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'-	DATE
R000000							
	This visit was f	or the State	ROO	00000	DISCLAIMER: Preparation ar	nd	
			100	70000	implementation of this plan of correction does not consitute		
	Residential Lic	ensure Survey.					
					admission or agreement by		
	_	May 28 and May 29,			Rittenhouse Senior Living of		
	2013				Indianapolis of the truth of the		
					facts, findings, or other		
	Facility number	r : 003282			statements as alleged by the		
	Provider numb				preparer of the Survey/inspect		
	AIM number : I				dated May 30, 2013. Rittenho	use	
					Senior Living of Indianapolis		
					specifically reserves the right	:O	
	_	Michelle Hosteter RN,			move to strike or exclude this		
	TC				document as evidence in any		
	Gloria Bond, R	N			civil, criminal or administrative		
				action not related directly to licensing and/or certification			
	Census bed typ	ne·			this facility or provider.		
	Residential: 84	•			ting lacinty of provider.		
		T					
	Total : 84						
	_						
	Census payor	type:					
	Medicaid: 11						
	Other: 73						
	Total: 84						
	- -						
	Sample: 7						
	Gampie. I						
	These state fin	dings are cited in					
		•					
	accordance wit	th 410 IAC 16.2.					
	Quality Review	was completed by					
	Tammy Alley F	RN on June 3, 2013.					
		-					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 1 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/29/2013			
			B. WING		03/29/2013		
	ROVIDER OR SUPPLIER	/ING OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
R000036	resident's physic legal representation noticed: (1) a significant diphysical, mental, (2) a need to alter that is, a need to form of treatment consequences or of treatment. Based on record interview, the fatthe physician in change in diet of the hospital for reviewed for change in diet. Findings include The clinical record was reviewed to Diagnoses including the clinical record was reviewed to Diagnoses in Clinical record was reviewed to Diagnoses in Clinical record was r	- Deficiency set immediately consult the sian and the resident's ve when the facility has ecline in the resident's or psychosocial status; or retreatment significantly, discontinue an existing due to adverse to commence a new form or dreview and acility failed to notify numediately of a porders after return from or of 5 residents anges in status in a sident #49) e: ord for Resident # 49 on 5/29/13 at 11 a.m. added, but were not or II Diabetes, epression, and or the hospital on a form lmaging indicated on 1/18/13, and been admitted for d hyperglycemia. ptoms were indicated	R000036	1) What corrective action(s) who be accomplished for those residents found to have been affected by the deficient practice: All Licensed Nurses is receive in-service education regarding the facility "Notificat Policy - Physicians, Residents and Responsible Parties". 2) How the facility will identify oth residents having the potential be affected by the same defic practice and what corrective action will be taken: All resident have the potential to be affected. 3) What measures who be put into place or what syste changes the facility will make ensure that the deficient pract does not recur: The Licensed Nurses shall receive in-service education to include the facility policy "Notification Policy - Physicians, Residents, and Responsible Parties". This training shall also include proposition of these notifications. Licensed Nurses who do not	shall ion s ner to ient nts vill emic to ice e y		

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 2 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		A. BUILDING	OO CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/29/2013	
			B. WING	CT ADDRESS CITY STATE TIP CODE	05/29/2013
NAME OF I	PROVIDER OR SUPPLIER	L Comment		ET ADDRESS, CITY, STATE, ZIP CODE W 96TH ST	
RITTEN	HOUSE SENIOR LIV	/ING OF INDIANAPOLIS		ANAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	1/18/13 from he Speech Pathol liquid via cup of Dysphagia cho discharge form the hospital indicated sometime chopped 2000 concentrated sometime cup 1:1 supervintake" The physician's indicated, "R mech soft diet, straws" the was dated 3/18. There were no physician's prophysician's prophysician's ord clarification or clarification or clarification or clarification or clarification or clarification was of the diet or with the clarification was of the diet or with the clarification or clarification was of the diet or with the clarification or clarification was of the diet or with the clarification or clarification was of the diet or with the clarification or clarification was of the diet or with the clarification was of the diet or with the clarification or clarification was of the diet or with the clarification or clarification was of the diet or with the clarification or clarification was of the diet or with the clarification was of the diet or with the clarification or clarification was of the diet or with the clarification or clarification was of the diet or with the clarification or clarification was of the diet or with the clarific	pped diet" The dated 1/21/13 from dicated, "Dysphagia calorie diet, no weets thin liquid with isionencourage po sorders dated 1/21/13 es [resident] to have thin liq [liqiud], but no physician's signature 3/13. nurse's notes, gress notes, or other ers indicating changes in diet status. with the Residential on 5/29/13 at 4:10 p.m., she did not know if the notified for clarification hen the diet was esident #49 after the facility after		follow the "Notification Policy correctly shall receive disciple action in the form of a writter reprimand and potential for termination from their position should there be re-occurence. How the corrective action(s) be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place system for new orders received has been put into place. All orders are reviewed by either Resident Care Director or Director of Memory Care to ensure proper transcription at follow through.5) By what dathe systemic changes will be completed: Date of completion 7/15/13	inary n n e.4) will ur, e:A red new r the

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 3 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
			B. WING			05/29/	2013
				_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t.			96TH ST		
RITTENH	IOUSE SENIOR LIV	VING OF INDIANAPOLIS			APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL			ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000148	(e) The facility sh grounds, and equation, in good that may adverse welfare of the rest follows: (1) Each facility simplement a writt maintenance to eupkeep of the face (2) The electrical appliances, cords sources, fire alarnshall be maintainfunctioning and celectrical codes. (3) All plumbing scomply with state (4) At least yearly systems shall be Based on obserecord review, secure potentiatheir dementia. This had the poresidents residents residents obsein the dementia. Findings includes the Maintenance of the Mainten	afety Standards - Deficiency all maintain buildings, sipment in a clean direpair, and free of hazards by affect the health and sidents or the public as thall establish and en program for insure the continued sility. system, including systems, ed to guarantee safe ompliance with state thall function properly and plumbing codes. A heating and ventilating inspected. Ervation, interview and the facility failed to ally hazardous items in unit's activity area. Otential to affect all 34 ing in the memory care on the facility failed to a environment for 1 of 5 rved that did not reside a unit. (Resident #55) de: nvironmental tour with the Director on the unit, on 5/29/2013 at	R000	0148	1) What corrective action(s) who accomplished for those residents found to have been affected by the deficient practice: The container contain the nail polish, clippers, hair pi and moisturizing lotion, as well the metal fork found in a drawk were removed and relocated to safe and secured storage area during the survey. The extens cord observed was immediated removed from the resident's room. 2) How the facility will identify other residents having potential to be affected by the same deficient practice and who corrective action will be taken: residents have the potential to affected. 3) What measures will affected.	ing ns I as er, o a a ision ly the nat All be	07/15/2013
	1. During the environmental tour with the Maintenance Director on the Dementia care unit, on 5/29/2013 at 1:10 p.m., a plastic container was				same deficient practice and wh corrective action will be taken: residents have the potential to	All be	

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 4 of 18

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIHIDING	00	COMPLETED	
			A. BUILDING		05/29/2013	
			B. WING	T ADDRESS CITY STATE ZIR CORE		
NAME OF P	PROVIDER OR SUPPLIE	₹		T ADDRESS, CITY, STATE, ZIP CODE		
DITTENIL	IOUGE SEMIOD U	VING OF INDIANAPOLIS		W 96TH ST		
	IOUSE SEINIOR LI	VING OF INDIANAPOLIS	IIIDIF	NAPOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		unsecured easily		be put into place or what syste		
	•	board. The container		changes the facility will make ensure that the deficient pract		
	contained nail	clippers, nail polish		does not recur:Routine safety		
	remover, 30 bo	ottles of nail polish, a		rounds will be put into place in	n an	
	couple of hair	pins, and a bottle of		attempt to ensure the facility		
	moisturizing lo	tion. In addition a		remains free of hazards. Staf	f	
	_	found in an easily		involved shall be trained to		
	accessible dra	•		recognize and remove potenti	l l	
				hazards at all times.4) How the corrective action(s) will be	ie	
	l In an interview	on 5/29/2013 at 1:12		monitored to ensure the defici	ent	
		Memory Care Director,		practice will not recur, i.e., wh		
		potentially hazardous		quality assurance program wil	l l	
	·	-		put into place:The Director of		
	•	locked up or out of		Memory Care, or her designed		
	reach.			shall complete safety rounds of	l l	
				the memory care unit two time per week for four weeks.	es	
		rvation on 5/29/2013 at		Following the initial four week	s.	
	•	ng the environmental		safety rounds will be conducted	l l	
	· ·	#55 had an iron's		one time per week ongoing.		
	electrical cord	plugged into to a light		Maintenance Director, or his		
	weight extension	on cord which was		designee, shall check all		
	plugged into th	ne wall.		apartments to be sure extensi	on	
				cords are not being used. Following this initial review,		
	The Maintenar	nce Supervisor in an		routine checks will be perform	ed	
		29/2013 at 1:31 p.m.,		weekly ongoing. In addition,		
		use of extension cords		Housekeeping staff will be tra	ined	
		ts were not permitted in		to be observant of any extens		
	the facility.			cords that may have been add	ded	
	aro raomity.			while cleaning resident	ho	
	The "Resident	Handbook" was		apartments.5) By what date t systemic changes will be	ile	
		/29/2013 at 5:30 p.m.,		completed:Date of completion	:	
				7/15/13		
		under "Safety," " hot				
	plates, electric					
	extension cord	s are not permitted."				

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 5 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			A. BUI B. WIN		05/29/2013		2013
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/ 96TH ST		
DITTENIA	IOLISE SENIOD LIV	/ING OF INDIANAPOLIS			IAPOLIS, IN 46260		
IXIIILINII	OUSE SENIOR EN	TING OF INDIANAL OLIS		INDIAN			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000155	410 IAC 16.2-5-1	• •					
		afety Standards - Deficiency					
		ıll have an effective te disposal program in					
		410 IAC 7-24. Provision					
		the safe and sanitary					
		vaste, including dressings,					
	•	, and similar items.					
		rvation and interview	R00	00155	1) What corrective action(s) w	rill	06/21/2013
	the facility faile	d to ensure garbage			be accomplished for those		
	was disposed of				residents found to have been		
	sanitary manor for 2 of 2 observations				affected by the deficient		
	of the outside dumpster area. This				practice:The dumpster area was cleared and the lid of the	as	
	had the potential to affect all 84				dumpster closed on 5/30/13.2)	\	
	residents residing in the facility.				How the facility will identify oth		
	residents residi	ing in the facility.			residents having the potential		
					be affected by the same defici-		
	Findings includ	e:			practice and what corrective		
					action will be taken:All residen	ts	
	In an observati	on with the			have the potential to be		
	Maintenance D	irector on 5/28/2013 at			affected.3) What measures w		
	10:45 a.m., the	outside garbage			be put into place or what syste changes the facility will make t		
	disposal area v	vas observed with the			ensure that the deficient practi		
	="	ooden door open and			does not recur:The waste	00	
		ss mirror, a small			disposal contractor for the faci	lity	
		inidentifiable waste, a			is being contacted to determin	e if	
	•	nay and a white piece			a more "user friendly" dumpste	er	
		•			can be obtained. If this is not		
		the ground in front of			option, the facility will gather tr	ash	
	•	One of the lids to the			throughout the shifts in large	اممان	
	dumpster was	observed open.			covered cans located in the so utility room. These cans shall		
					emptied into the dumpster by	De	
	In an observati	on during the			Maintenance personnel a		
	environmental	tour with the			minimum of two times daily to		
	Maintenance S	upervisor on			ensure the dumpster lid is		
		p.m., the outside			properly closed and no debris is		
		sal area had the			left in the area surrounding the		
	• •	ter door open, one of			dumpster.4) How the corrective	/e	
	surrounding ou	tor door open, one or			action(s) will be monitored to		

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 6 of 18

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/29/2013				
	PROVIDER OR SUPPLIEF	VING OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE ROPRIATE COMPLETION DATE			
	piece of furnitudumpster. In an interview Supervisor on he indicated the left open becauthe staff to open mirror had bee	lids open and a white re by the side of the with the Maintenance 5/29/2013 at 1:02 p.m., e lid to the dumpster is use it is too heavy for en it and the glass in there the day before dispersion been too busy to		ensure the deficient pract not recur, i.e., what quali assurance program will be into place: The Maintenan Director, or his designee monitor the dumpster are minimum of two times datensure the dumpster lided closed and no trash, or of debris, is placed outside dumpster. Proper trash as shall be reviewed with all members. 5) By what daten systemic changes will be completed: Date of comp 6/21/13	ty pe put pe put pe a a puily to remains puther of the disposal I staff te the			

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 7 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE :	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
			B. WIN			05/29/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t .					
DITTENIL	IOUSE SENIOD LIV	VING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260				
KILLEIN	IOUSE SEINIOR LIV	VING OF INDIANAPOLIS		INDIAN	IAPOLIS, IN 40200		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000214	410 IAC 16.2-5-2						
	Evaluation - Deficiency						
	` '	of the individual needs of					
		all be initiated prior to					
		nall be updated at least					
		I upon a known substantial ident 's condition, or more					
		ent 's or facility 's request.					
		shall evaluate the nursing					
	needs of the resid						
	Based on record review and interview, the facility failed to have an updated evaluation reflecting the		R00	00214	1) What corrective action(s) w	/ill	07/15/2013
					be accomplished for those		
					residents found to have been		
	changes in dietary status of 1 of 7				affected by the deficient practi	ce:	
	U	•			All Licensed Nurses shall rece	_	
		wed for evaluations in			in-service education to checkli		
	a sample of 7.	(Resident # 49)			for admission and re-admissio		
					the facility, and the proper sys	tem	
	Findings includ	le:			for receipt of new orders. Checklists have been complet	od	
					for Licensed Nurses to utilize t		
	1. The clinical i	record for Resident #			ensure physician orders,	.0	
	49 was reviewe	ed on 5/29/13 at 11			including diet orders, are prope	erlv	
	a.m. Diagnose	es included, but were			transcribed upon admission or		
	_	Гуре II Diabetes,			re-admission to the facility. A		
	Alzheimer's, de	• •			system for new orders is in pla		
	•	epression, and			and all new orders are reviewed	ed	
	abnormal gait.				by either the Resident Care		
					Director or Director of Memory	′	
		the hospital on a form			Care to ensure proper		
	titled, "Medical	Imaging			transcription and follow through.2) How the facility wil	ı	
	Questionnaire"	indicated on 1/18/13,			identify other residents having		
	Resident #49 h	nad been admitted for			potential to be affected by the	uic	
		d hyperglycemia.			same deficient practice and wi	hat	
	-	ptoms were indicated			corrective action will be taken:		
	as difficulty swa	•			residents have the potential to		
	•	<u> </u>			affected.3) What measures w	ill	
	• •	gress notes dated			be put into place or what syste		
		ne hospital indicated,			changes the facility will make t		
	•	thology recommended			ensure that the deficient practi	ice	
	thin liquid via c	up only. No straws,			does not recur:The Licensed		

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 8 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPL			COMPLI	ETED
						05/29/2	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
					/ 96TH ST		
RITTEN	HOUSE SENIOR LI	VING OF INDIANAPOLIS		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	Dysphagia cho	opped diet"			Nurses shall receive in-service	;	
	The discharge form dated 1/21/13				education to checklists for		
					admission and re-admission to)	
	_				the facility, and the proper sys	tem	
	from the hospi				for receipt of new orders.The		
	"Dysphagia (chopped 2000 calorie			nursing staff shall utilize the		
	diet, no concei	ntrated sweets thin			checklist provided to assist in		
	liquid with cup	1:1			proper transcription and		
		ncourage po [by			implimentation of physician		
	mouth] intake.				orders upon admissiion or		
	i modinj intako.	•••			re-admission to the facility. The system for new orders is in place.		
	l <u>-</u>				with the Resident Care Director		
	The physician's recapitulation for				Director of Memory Care	01 01	
		ch, and April indicated			reviewing all new orders to		
	the diet as No	concentrated sweets.			ensure proper transcription an	d	
	There was no	information regarding			follow through.Licensed Nurse		
		ft 2000 calorie diet or			who do not follow the proper		
		p with 1:1 supervision			procedures as listed above sh	all	
	and no straws.	•			receive disciplinary action in the	ne	
	and no shaws.				form of a written reprimand an	d	
					potential for termination from t	heir	
	•	ysician's orders dated			position should there be		
	1/21/13 indicat	ting, "Res [Resident]			re-occurrence.4) How the		
	to have mech	[mechanical] soft diet,			corrective action(s) will be	.	
	thin lig [liguid],	but no straws"			monitored to ensure the defici- practice will not recur, i.e., who		
					quality assurance program wil		
	There were no	other nursing notes,			put into place:The Resident C		
	physician's pro	o ,			Director, or her designee, sha		
	l · •	_			review new admission and		
	· •	lers indicating any			re-admission checklists within	72	
	_	status found in the			hours to ensure ongoing		
	chart.				compliance by the Licensed		
					Nurses of the systems put into		
	The only note	found in the chart from			place. All new orders shall be		
		as dated 5/13/13 and			reviewed by either the Reside	nt	
		ew assessmentDiet			Care Director or Director of		
	<u>-</u>				Memory Care ongoing.5) By		
		post hosp.[hospital] per			what date the systemic change	es	
		nerapy] : Mech.			will be completed:Date of		
	[Mechanical] §	Soft [sign for no] straws			completion: 7/15/13		

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 9 of 18

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/29/2013
	PROVIDER OR SUPPLIER HOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W	ADDRESS, CITY, STATE, ZIP CODE / 96TH ST APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	O BE COMPLETION
	Current signed orders note diet: NCS [No concentrated sweets] Please clarify diet-does he need Mech. Soft [sign for no] straws NCS? Unstable BS's [blood sugars] monitor how many sweets he consumes-encourage low carbohydrate items Evaluate use vs [versus] risk of Atelvia [medication to treat bone loss] wkly [weekly] dt [due to] side effects possible esophagitis/gastritis [swelling of espophagus] and resident with wt. [weight] loss" In an interview with the Residential Care Director on 5/29/13 at 11:30 a.m., she indicated the current evaluation of resident should be in the chart and should show any changes related to diet status. On 5/29/13 at 4:10 p.m., she indicated she did not know when the diet was changed for Resident #49 after readmission to the facility after hospital stay on 1/21/13. She also indicated she could not find any documentation from the dietary department regarding change in diet status.			

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 10 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WINC	j		05/29/	2013
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1251 W	96TH ST		
RITTENH	OUSE SENIOR LIV	/ING OF INDIANAPOLIS		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000217	410 IAC 16.2-5-2						
	Evaluation - Defic	-					
		npletion of an evaluation,					
		appropriately trained staff lentify and document the					
		ovided by the facility, as					
	follows:	ornada by the lacinity, ac					
	(1) The services of	offered to the individual					
	resident shall be	appropriate to the:					
	(A) scope;						
	(B) frequency;						
(C) need; and(D) preference;of the resident.(2) The services offered shall be reviewed							
and revised as appropriate and discussed by							
		acility as needs or desires					
	-	e facility or the resident					
	may request a se						
		oon service plan shall be					
		by the resident, and a se plan shall be given to the					
	resident upon req						
	•	on and documentation of					
	services provided	l is needed if evaluations					
	•	e initial evaluation indicate					
	no need for a cha						
	` '	on of medications or the					
		ential nursing services, or a licensed nurse shall be					
		ication and documentation					
	of the services to						
	Based on recor		R00	0217	What corrective action(s) w	ill	07/15/2013
		acility failed to have			be accomplished for those		
		eflecting services			residents found to have been		
	provided for 2	•			affected by the deficient praction		
	•	ervice plans (Resident			The Service Plan for all reside	nts	
		and no signature from			shall be audited to ensure the Service Plan addresses reside	nt	
	•	•			needs, preferences, current	111	
		consible party for 2 of 5			physician orders and specific		
	records review	ed for signatures on			medical requirements, such as	;	
			1				

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 11 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
						05/29/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
DITTELII		, (IN 10, 05, IN DIAN ABOUTO			/ 96TH ST		
RITTEN	HOUSE SENIOR LI	VING OF INDIANAPOLIS		INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the service plans in a sample of 7. (allergies, are addressed.2) H	ow	
	Resident #11 a	•			the facility will identify other		
	Troolaone ii Tr	and 700)			residents having the potential	to	
		Ja.			be affected by the same defici	ent	
	Findings include	ie:			practice and what corrective		
		16 5			action will be taken:All resider	ıts	
		record for Resident #			have the potential to be	•••	
	49 was review	ed on 5/29/13 at 11			affected.3) What measures w		
	a.m. Diagnose	es included, but were			be put into place or what syste changes the facility will make		
	not limited to,	Type II Diabetes,			ensure that the deficient pract		
	Alzheimers, de	• •			does not recur:The Service Pl		
	abnormal gait.				for all residents shall be audite		
	abriormai gait.				to ensure the Service Plan	,	
	_ , , ,				addresses resident needs,		
		n the hospital on a form			preferences, current physiciar	1	
	titled, "Medica	Imaging			orders and that specific medic		
	Questionnaire'	' indicated on 1/18/13,			requirements, such as allergie	s,	
	Resident #49 I	nad been admitted for			are addressed. Upon routine s	ix	
	dehydration ar	nd hyperglycemia.			month reviews, staff responsit	ole	
		ptoms were indicated			for Service Plans shall obtain		
	as difficulty sw	•			signature on Service Plan of		
	1	•			resident or responsible party.		
		ogress notes dated			Service Plan is not reviewed in		
		ospital indicated, "			person, staff member shall manner notation on Service Plan of ve		
	-	logy recommended thin			review.4) How the corrective	IDai	
	liquid via cup o	only. No straws,			action(s) will be monitored to		
	Dysphagia cho	opped diet"			ensure the deficient practice v	vill	
					not recur, i.e., what quality		
	The discharge	form dated 1/21/13			assurance program will be put	[
	from the hospt				into place:Upon development	of	
					the initial Service Plan the		
		chopped 2000 calorie			following shall be referenced t		
	· ·	ntrated sweets thin			ensure all of the resident need		
	liquid with cup				and preferences are addresse		
	supervisione	ncourage po [by			Admission Orders, Admission		
	mouth] intake				Assessment, Admitting History	•	
					Physical, recent Labs and Nui Notes. The Service Plan	ses	
	The physician'	s recapitulation for			document will be modified to		
					include "prompts" to assist in		
	rebluary, Mar	ch, and April indicated			module prompts to assist in		

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 12 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPL 05/29/	ETED	
			B. WIN			03/29/	2013
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					96TH ST		
RITTEN	HOUSE SENIOR LIV	VING OF INDIANAPOLIS		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		concentrated sweets.			ensuring all pertinent information	ion	
		information found in the			is addressed in the Service Plan.5) By what date the		
	chart regarding	mechanical soft 2000			systemic changes will be		
	calorie diet or t	the use of a cup with			completed:Date of Completion	า:	
	1:1 supervisior	n and no straws.		7/15/13			
		ysician's orders dated					
	1/21/13 indicat	ing, "Res [Resident]					
		mechanical] soft diet,					
	thin liq [liquid],	but no straws"					
	and the first of the second se						
	There was no other nursing notes,						
	physician's progress notes,						
	physician's orders indicating any						
	change in diet status found in the						
	chart.						
	onart.						
	The only note t	found in the chart from					
	•	as dated 5/13/13 and					
		ew assessmentDiet					
	noted 1/21/13						
	ST[Speech Therapy] : Mech						
	[Mechanical] . Soft [sign for no]						
	straws Current signed orders not diet: NCS [No Concentrated Sweets]						
	_	-					
		diet-does he need					
		in for no] straws NCS?					
		[blood sugars] monitor					
	how many sweets he						
	consumes-encourage low						
	carbohydrate items Evaluate use vs						
	[versus] risk of Atelvia [medication to						
	treat bone loss] wkly [weekly] dt [due					
	to] side effects	possible					
	esophagitis/ga	stritis and resident with					

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 13 of 18

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 05/29/2013			
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Wt. [weight] loss"		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT TAG DEFICIENCY)				
	In an interview Care Director of a.m. indicated of resident show and diet status. On she indicated she diet was che diet w	with the Residential on 5/29/13 at 11:30 the current evaluation uld be in the chart and my changes related to 5/29/13 at 4:10 p.m. he did not know when anged for Resident mission to the facility tay on 1/21/13. She she could not find any from dietary larding change in diet 1's record was 28/2013 at 12:30 p.m. uded, but were not entia, depression, and "Pre-assessment dated 4/3/13 gies to shellfish and vision with toileting. , "Admission Nursing dated 4/4/13 indicated, allfish, and urinary ith possible need for					

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 14 of 18

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COMF 05/29	E SURVEY LETED 9/2013		
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	mention of alle under continent resident was continent resident was continent and bladder). Signed by Resident #8 reviewed on 5/Diagnoses including the sident for the side							

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 15 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NU		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		B. WING			05/29/2013		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER				l			
DITTENHALIOE OF MODEL WINDOWS INDIANABOLIO					/ 96TH ST		
RITTENH	IOUSE SENIOR LIV	/ING OF INDIANAPOLIS		INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY)		DATE
R000300	410 IAC 16.2-5-6	(c)(4)					
	Pharmaceutical S	Services - Deficiency					
	(4) Over-the-cour						
		s, and biologicals used in					
	-	e labeled in accordance					
		epted professional					
	•	lude the appropriate					
		utionary instructions and					
	the expiration date. Based on observation, record review,			0200	4) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		08/02/2013
			R000300	10300	What corrective action(s) we be accomplished for those	111	00/02/2013
	•	the facility failed to			residents found to have been		
		counter medication			affected by the deficient		
	labeled with resident information for 1 of 5 residents observed during medication pass (Resident #65) and failed to have a correct medication				practice:All Licensed Nurses s	hall	
					receive in-service education to include the "Medication Administration" policy that		
	administration label for 1 of 5 residents observed during medication				includes proper labeling of all		
					medications.2) How the facility	•	
		•			will identify other residents have	-	
	pass. (Resident #66) Findings include: 1. During the medication pass with on 5/29/13 at 8:25 a.m., with LPN #1, a bottle of I Cap vitamins was observed				the potential to be affected by		
					same deficient practice and wh		
					corrective action will be taken:All		
					residents have the potential to affected.3) What measures wi		
					be put into place or what syste		
					changes the facility will make t		
					ensure that the deficient practi		
	to have no written information regarding resident name or physician				does not recur:The Licensed		
					Nurses shall receive in-service)	
	•				education to include the facility	/	
	ioi ixesidelii #C	for Resident #65.			"Medication Administration"		
		=			policy. Training shall include		
		with LPN #1 on			proper labeling of all medication		
	5/29/13 at 8:26 a.m., she indicated they usually have the resident's name and the physician's name written on				with emphasis placed on OTC		
					medication and medication		
					requiring a change of direction label.Licensed Nurses who do		
	the bottle.				follow the "Medication	HOL	
	ine bottle.				Administration" policy correctly	,	
	2 During the m	pedication pass on			shall receive disciplinary action		
	Z. During the II	nedication pass on			the form of a written reprimand		

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 16 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/29/2013			
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CTION (X5) JLD BE COMPLETION ROPRIATE DATE tion from			
	observation was medication has information writhe MAR (Med Record). The Lindicated, "Med [milligrams] 2 the MAR that indicated, "Medicated, "Medicated, "Medicated the resident was medication this and that the or the correct am not updated the yet. In an interview Care Director of she indicated have a change the bottle. A policy titled, Administration provided by the Director on 5/2 The policy indi Medication nar form, dose, routed.	tten than the order on ication Administration abel on the bottle toprolol Tartate 50 mg ab po [by mouth] daily." LPN #1 provided toprolol 25 mg 1 po with LPN #1 on 6 a.m., she indicated as getting the 8 way to save money der on the MAR was ount and that they had be label on the bottle with the Residential on 5/29/13 at 9:00 a.m., the medication should be of direction label on 18.80 Medication 19.80 Medication 19.80 Medication 19.80 Medication 19.81 Medication 19.81 Medication 19.82 Medication 19.83 Medication 19.84 Medication 19.85 Medication		and potential for terminal their position should their re-occurrence.4) How the corrective action(s) will be monitored to ensure their practice will not recur, i.e. quality assurance prograput into place: Audits of the medication carts shall be performed by either their Care Director, or her destwo times per week for tweeks, one time per week week, one time every other one month and one to other month ongoing.5) date the systemic change completed: Date of Comp. 8/2/13 to accommodate at time line.	e be le le le le deficient e., what Im will be le Resident signee, vo lek for one leer week me every By what les will be leletion:		

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 17 of 18

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00 	COMPLETED 05/29/2013		
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	direction chang	e sticker applied to rescription label does					

State Form Event ID: YYLR11 Facility ID: 003282 If continuation sheet Page 18 of 18